Supreme Court, U.S.
FILED
JUL 29 1999
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(2)

No. 99-28

IN THE

Supreme Court of the United States

PHYSICIANS INSURANCE COMPANY OF WISCONSIN; PAUL K.H. FIGGE, JR., M.D.; WISCONSIN PATIENTS COMPENSATION FUND,

Petitioners,

v.

KIMBERLY SCHREIBER, a minor by her guardian ad litem, JOHN KRUEGER; GERALD SCHREIBER and JANICE SCHREIBER,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF WISCONSIN

RESPONDENTS' BRIEF IN OPPOSITION

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STATEMENT OF THE CASE

A. Fundamental Facts

The petitioners outline many of the facts of this case accurately, but fail to include facts of importance and inaccurately outline others. The respondents will supplement those facts as needed and point out the inaccuracies.

This case derives from a fundamentally simple fact situation. Janice Schreiber delivered her first two children by cesarean section. When she became pregnant a third time, she was given the option by Dr. Paul Figge of attempting a vaginal (VBAC — vaginal birth after cesarean) delivery. There is a risk of uterine rupture when a vaginal birth is attempted after a cesarean. (Pet. App. D at 54a, 55a). For that reason, either a vaginal delivery or a cesarean were reasonable medical options. Wisconsin informed consent law requires that a physician outline all alternative, viable medical modes of treatment, and, in fact, Dr. Figge discussed other options with Mrs. Schreiber. After talking with Dr. Figge Mrs. Schreiber decided, before going into labor, to try a VBAC. It is undisputed that if, prior to labor, Mrs. Schreiber had chosen to have a cesarean that Dr. Figge would have performed it. In fact, Dr. Figge had never even attempted a VBAC with a woman who had two prior cesareans before Mrs. Schreiber. (Pet. App. D 54a, 55a; R. 96 at 68-69). He had always delivered such children by cesarean.

After Mrs. Schreiber went into labor, two things changed that caused her to reconsider her decision to try a vaginal delivery. First, her labor was following the same course as it had in her first pregnancy, which ended in a cesarean after

36 hours of unproductive labor. (Pet. App. D at 3a). Mrs. Schreiber did not wish to relive that unpleasant experience. Second, early in her labor she began to experience severe upper abdominal pain, unrelated to labor. This pain was so severe that she could not walk without assistance even between contractions. Dr. Figge was unable to diagnose the cause of this pain. (Pet. App. D at 4a; R. 96 at 109-115).

The combination of these two factors caused her to change her mind with respect to her choice for delivering her child. On at least four separate occasions over the course of five hours she communicated her request for a cesarean to Dr. Figge or his staff. (Pet. App. D at 12a). Those requests were ignored or rejected. Finally, Mrs. Schreiber gave up trying to tell Dr. Figge to perform a cesarean, as her attempts were fruitless and she did not know what more she could do. (Pet. App. D at 12a). Dr. Figge ignored her requests because, even though a cesarean was a viable medical option (due to the risk of uterine rupture), he preferred proceeding with the VBAC. (Pet. App. B at 25a, 26a).

Tragically, Mrs. Schreiber's uterus ruptured about two hours after her last unsuccessful attempt to tell Dr. Figge to perform a cesarean. Her daughter, Kimberly, was deprived of oxygen as a result and is now a spastic quadriplegic, unable to speak, move her head or control her body. It is stipulated that had she been born by cesarean at any time prior to the rupture that she would be a healthy and normal child. (Pet. App. D at 5a).

B. The Petition Misstates Some of the Facts of this Case.

In the petitioners' Statement of the Case, there are a number of inaccuracies and misleading statements. While it is the position of the respondents that no constitutional issue would be presented even if the facts as outlined by the petitioners were true, nonetheless, consistent with the requirement of Supreme Court Rule 15, the respondents will point out the inaccuracies.

1. *The petitioners misstate the record when they contend that a VBAC in these circumstances is safer than a cesarean.*

On page 4 of the petition, the petitioners assert that prevailing medical research showed that a VBAC presented less risk than a cesarean. This is simply not an accurate reflection of the record. A fair characterization of the record is as follows. There was literature at the time of Kimberly Schreiber's delivery which indicated that a VBAC could be safely undertaken by a woman who had had a single prior cesarean section. (R. 92 at 26-27). For women who had had two or more prior cesareans, there was not enough clinical data to fully assess the safety. For that reason, the American College of Obstetrics and Gynecology recommended that women with one prior cesarean be encouraged to try a VBAC while no such recommendation was made with respect to women who had had two or more prior cesareans. (R. 80: Exhibits 10A-11A). Mrs. Schreiber fell into the latter category. It was known at the time that the risks of a VBAC fall primarily on the fetus, whereas the risks of cesarean tend to put the mother at more risk. (R. 90 at 20-21). In any event, it was undisputed that either procedure was medically acceptable. As was pointed out earlier, this was the first time

Dr. Figge had even attempted a VBAC with a patient who had had two prior cesareans. (R. 96 at 68-69). The normal method of delivery in such patients was a repeat cesarean.

2. *The petitioners misstate the record when they imply that Mrs. Schreiber had digestive pain unrelated to the ultimate rupture of the uterus.*

On page 5 of the petition, the petitioners state that Mrs. Schreiber began experiencing severe upper epigastric pain during labor. This statement may be misleading for two reasons. First, it is important to point out that this pain had nothing to do with labor or contractions. (Pet. App. D at 4a). It was a new severe and disabling pain located at the top of her abdomen. Second, no cause for the pain was ever diagnosed by Dr. Figge. The term epigastric might imply that the pain was digestive in nature, but no proof was ever offered to that effect. Dr. Figge stated that he did not know what caused the pain. (Pet. App. D at 4a). The respondents' experts testified that the pain was an early sign of the beginning of the rupture of the uterus.

3. *The petitioners misstate the record when they assert that a uterine rupture was not occurring at the time Dr. Figge examined Mrs. Schreiber in the early afternoon.*

On page 6 of the petition, the petitioners state that at the time of Dr. Figge's exam a uterine rupture was not occurring. This is somewhat misleading. A frank or catastrophic rupture is always accompanied by obvious symptoms. However, at the beginning of a rupture the only sign or symptom may be pain. The respondents' experts testified that abdominal pain is a danger sign that provides early warning of an impending

catastrophic rupture. (R. 98 at 28-29). While Dr. Figge did not believe that such an early rupture was taking place, he could not rule it out based solely on a clinical exam. (R. 99 at 130-133).

4. *The petitioners misstate the record when they contend that Mrs. Schreiber did not refuse to go forward with the VBAC and that the findings of the supreme court are contrary to the trial court in that regard.*

On page 7 of the petition, the petitioners state that Dr. Figge testified that he thought Mrs. Schreiber had agreed with his plan to continue with the VBAC, and that Mrs. Schreiber did not refuse the treatment. Then on page 13, the petitioners assert that the Supreme Court of Wisconsin made a finding that Mrs. Schreiber had withdrawn her consent to the VBAC contrary to the decision of the circuit court. These contentions are simply not in accord with the record.

The circuit court found that Mrs. Schreiber was denied a choice at 1:00 p.m. (Pet. App. D at 68a, 69a). At the court of appeals level, Dr. Figge attacked this finding and contended that the finding was clearly erroneous. The court of appeals determined that the circuit court's finding was supported by credible evidence and refused to overturn that finding. (Pet. App. B at 32a, 33a). The supreme court affirmed this finding of both the circuit court and the court of appeals by holding that consent was withdrawn.

The supreme court held that a physician has a duty to offer a patient a choice once consent is withdrawn. (Pet. App. A at 13a-15a). It went on to conclude that Mrs. Schreiber's consent was in fact withdrawn, based upon the factual

findings that the circuit court made. (Pet. App. A at 11a-13a). In light of this record, it is simply wrong for the petitioners to state that Mrs. Schreiber consented to the continuation of the VBAC and that the supreme court made this finding contrary to the circuit court.

REASONS FOR DENYING THE WRIT

I.

THE DECISION OF THE WISCONSIN SUPREME COURT DOES NOT REQUIRE TREATMENT ON DEMAND.

The petition is based entirely upon the petitioners' misreading of the decision of the Wisconsin Supreme Court. The petitioners claim that the court held Dr. Figge liable because he failed to perform a cesarean section, as Mrs. Schreiber requested, and that consequently the effect of the court's decision is to compel physicians to perform a procedure or to provide treatment simply because the patient demands it. The court made no such ruling.

The supreme court held Dr. Figge liable because he failed to conduct an informed consent discussion with Mrs. Schreiber after she withdrew her consent to the VBAC procedure and he thus deprived her of the opportunity to choose a viable treatment option. The court stated:

> Having determined that Janice had withdrawn her consent to the VBAC, we must now examine the effect, if any, of that withdrawal. The Schreibers contend that her withdrawal both removed Figge's authority to continue with the VBAC and obligated him to conduct another informed consent discussion. We agree.

* * *

> This discussion, much like any other such discussion, would have entailed the risks and benefits at that time of the medically viable modes of treatment and again presented her an opportunity to choose her treatment.

(Pet. App. A at 13a). Again, the court stated:

> Consistent with Wis. Stat. § 448.30 Figge had a duty to conduct another informed consent discussion, and should have again presented Janice her treatment options and given her the opportunity to choose. His failure to do so was a violation of that duty.

(Pet. App. A at 17a).

In its summary, the court stated:

> [W]e determine that Janice Schreiber withdrew her consent to a vaginal delivery. Because alternative viable modes of medical treatment existed at that time, her withdrawal constituted a substantial change in circumstances obligating Figge under Wis. Stat. § 448.30 to conduct a new informed consent discussion and affording Janice the opportunity for a choice of treatment.

(Pet. App. A at 20a).

Contrary to the petitioners' assertion that the supreme court's decision will create treatment on demand, the court specifically stated:

> [T]his opinion should not be interpreted as creating a patient's right to demand any treatment she desires. Further, this opinion should not be interpreted as requiring physicians to perform procedures they do not consider medically viable, procedures for which they lack the appropriate expertise, or procedures to which they are morally opposed.

(Pet. App. A at 8a).

It was undisputed that a cesarean section was, in the words of Wis. Stat. § 448.30, a "viable medical mode of treatment" for Janice Schreiber. Consequently, consistent with the statute, Dr. Figge was required to give her the opportunity to choose that treatment option. The supreme court did not hold, as the petitioners assert, that Dr. Figge was required to perform the cesarean section. The court only held that Dr. Figge was required to give Mrs. Schreiber the choice to have a cesarean section. The court found Dr. Figge liable, not because he failed to perform a cesarean section, but because he denied Mrs. Schreiber the opportunity to make a choice of a cesarean section — a viable mode of treatment that she had requested on four separate occasions over the course of five hours. Dr. Figge could have met his obligation under informed consent law by giving Mrs. Schreiber the opportunity to choose her treatment, acknowledging her request for a cesarean section, and either performing the cesarean section himself, just like he had done hundreds of times before, or bringing in another physician to perform

the procedure if he did not want to perform it. Instead, he chose to simply deny her an opportunity to choose a cesarean section because it was not the choice of treatment that he preferred. The supreme court determined that he could not deny Mrs. Schreiber the opportunity to make a choice of a cesarean section simply because he preferred another method of delivery. The court never held that he was obliged to do the cesarean section himself.

Thus, the petitioners' assertion that the court's decision would require a physician to perform or provide whatever procedure or treatment is demanded by the patient does not flow from the court's decision. There is simply nothing in the court's decision which compels a physician to provide a treatment that he/she does not wish to provide or believes is not "indicated" or "appropriate."

It is ironic that the petition asserts that the supreme court's decision would violate Dr. Figge's rights of self-determination when it is his conduct in forcing Mrs. Schreiber to continue with a treatment against her will which forms the basis for the court's decision. The right of the patient to make this choice is one which has long been recognized by courts throughout the nation. *See Bankert v. United States*, 937 F. Supp. 1169 (D. Md. 1996); *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *La Case v. Colier*, 434 So. 2d 1039 (La. 1983); *Natason v. Kline*, 186 Kan. 393, 350 P.2d 1093, 187 Kan. 186, 354 P.2d 670 (1960); *Union Pacific Railroad v. Botsford*, 141 U.S. 250 (1973).

There is absolutely nothing in the supreme court's decision which requires a physician to do anything other than offer patients the right to choose which treatment among

viable alternatives they prefer. To contend otherwise is to ignore the plain language of the decision. Because a physician is not required to do anything under the decision other than offer the patient a choice of treatment, the contention that Dr. Figge's right of self-determination is violated by forcing him to do a procedure that he does not prefer to do is simply unfounded.

II.

THE PETITION DOES NOT RAISE A CONSTITUTIONAL OR FEDERAL QUESTION.

A. The Wisconsin Decision Involves the Application of Wisconsin Statutory Tort Law and Does Not Implicate any Federal Right.

The decision of the Wisconsin Supreme Court is based solely on the Wisconsin informed consent statute, Wis. Stat. § 448.30. It does not involve the application of any federal law or statute. Because the decision does not compel a physician to provide patients with treatment on demand, there is no reasonable argument that it implicates any federal right. This case is simply a matter of Wisconsin tort law and should be left to the jurisdiction of the Wisconsin courts.

B. The Right of Bodily Integrity and/or Self-Determination Is Not Applicable to this Situation.

The constitutional right claimed by the petitioners is one of self-determination and/or bodily integrity grounded in the Fourteenth Amendment to the United States Constitution. The decisions cited by the petitioners are all cases which

involve the right to control one's own body.[1] The petitioners do not cite a single case in support of the proposition that the Fourteenth Amendment would prohibit reasonable laws which would compel individuals to take action, sometimes actions that they might not like or agree with. For instance, the Wisconsin informed consent statute, Wis. Stat. § 448.30, requires a physician provide a patient with information concerning alternate modes of medical treatment. If a physician believes that he should be able to make a medical judgment for the patient, he may disagree with the provisions of the statute. To claim, however, that he has a constitutional right to violate the statute because he disagrees is unfounded. No reasonable construction of the Fourteenth Amendment or the case law interpreting it would support such a conclusion.

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1. *See Cruzan v. Missouri Dep't of Health*, 497 U.S. 261 (1990), involving the rights of a vegetative child whom the parents wish to terminate life supports; *Ingraham v. Wright*, 430 U.S. 651 (1977), involving whether a child can be subject to certain corporal punishment at school; *Rust v Sullivan*, 500 U.S. 173 (1991), involving abortion rights; *Winston v. Lee*, 470 U.S. 753 (1985), involving the issue of whether or not a criminal defendant can be compelled to undergo surgery to remove a bullet which might be used for evidence; *Schmerber v. California*, 384 U.S. 757 (1966), whether blood can be taken against the consent of an accused; *Roe v. Wade*, 410 U.S. 113 (1973), involving abortion rights; *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), involving the informed consent rights of a patient; *Hurtado v. People of California*, 110 U.S. 516 (1884), involving the rights of a criminal defendant; *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983), involving the reproductive rights of a woman; *Washington v. Harper*, 494 U.S. 210 (1990), involving whether a criminal inmate can be forced to take psychotropic drugs; *Maher v. Roe*, 432 U.S. 464 (1977), involving a challenge to a regulation that limits Medicaid payments relating to abortions.

Clearly, the states have a legitimate interest in passing laws which would dictate how certain medical procedures are to be handled. Certainly, the states have the right to require physicians to treat patients in certain ways if the state decides that such laws meet the public interest. While the patient has a constitutional right to decide whether or not to receive that treatment, the physician has no constitutional right to violate those rules simply because he may disagree.

In any event, the issue is moot here because the decision of the Wisconsin Supreme Court simply does not compel a physician to provide any specific mode of treatment. The decision merely requires the physician to outline the viable treatment alternatives so that the patient has the right and ability to exercise the constitutional right to control his/her body. In essence, the decision requires a discussion, followed by the right of the patient to make the choice. It does not compel the physician to do the treatment; instead, it prohibits the physician from forcing the patient to follow a treatment protocol against his/her wishes.

III.

THE WISCONSIN COURT'S DECISION DOES NOT PUT PHYSICIANS AT RISK FOR MEDICAL MALPRACTICE CLAIMS.

The petitioners argue that the supreme court's decision subjects a physician like Dr. Figge to medical malpractice liability. The petitioners claim that, on the one hand, if a physician fails to provide a viable treatment requested by the patient, because the physician believes that the treatment is not "indicated," the physician will be subject to liability under the supreme court's decision. On the other hand, the

petitioners argue, if the physician accedes to the patient's request and there is a negative outcome, traditional malpractice liability may attach. The petitioners argue that physicians should not be subject to liability under the informed consent doctrine for failing to provide a viable treatment that they felt was not indicated. The petitioners also argue that physicians should not be subject to liability for malpractice when they provide a treatment which, although viable, is not "indicated." These arguments have no merit.

First, as explained above, the court's decision does not require a physician to provide a treatment which is requested by a patient. The decision only requires a physician to give the patient the opportunity to choose among viable treatments. Since all of the petitioners' arguments stem from the petitioners' erroneous assertion that the court's decision compels a physician to provide treatment requested by a patient, even if the physician feels the treatment is not "indicated," those arguments must be rejected.

Second, if a physician provides a treatment, his/her conduct should be judged by principles of negligence and informed consent, just as the conduct would have been judged prior to the court's decision in this case. If the treatment is a viable medical mode of treatment and it is provided with reasonable care, the physician is not subject to liability. *See* Wis. J.I. — Civil 1023. If the physician provides the treatment negligently, he/she should be subject to malpractice liability like any other physician who commits negligence.

Third, the petitioners' position that a patient should only be permitted to choose among "indicated" methods of treatment, but not all viable modes of treatment, is contrary to the clear and direct language of Wis. Stat. § 448.30 and case law interpreting that statute.

The petitioners' argument that a physician should not be required to give a patient the choice of a viable mode of treatment which is not "indicated" is a radical departure from existing Wisconsin law. The term "indicated" treatment, as used by the petitioners, is nothing but a shorthand phrase meaning the treatment that the physician feels is preferable. It cannot possibility mean anything else. This is so because the petitioners admit that the term "viable" is broader than the term "indicated," and the term "viable" is legally defined to mean "modes of treatment generally considered by the medical profession to be within the scope of current, acceptable standards of care." Wis. Admin. Code, sec. Med 18.02(3). If a "viable" mode of treatment is one which is within the standard of care for a physician to provide, then an "indicated" treatment is that treatment which, among the alternatives within the standard of care, the physician prefers. Under the petitioners' argument, a physician could be held liable only for failing to give a patient the choice of "indicated" treatments, but could not be held liable for failing to give a patient the choice of a viable mode of treatment which is not "indicated."

This argument is directly contrary to the language of Wis. Stat. § 448.30. That statute provides that a physician "shall inform the patient about the availability of all alternate, *viable* medical modes of treatment." (Emphasis added). The essence of the informed consent doctrine is that the patient has a right to make a reasonably informed choice of the method of treatment. If a physician is required under the statute to inform a patient about all viable modes of treatment, it necessarily follows that the patient has the right to choose from among those modes of treatment.

The notion that a physician's preferences should be permitted to dictate a patient's choice of treatment was rejected by the Wisconsin Supreme Court even before Wis. Stat. § 448.30 was enacted. *See Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 12, 227 N.W.2d 647 (1975). This was confirmed in *Martin v. Richards*, 192 Wis. 2d 156, 174, 531 N.W.2d 70 (1995), where the court stated that "the court in *Scaria* recognized that the standard for informed consent cannot be defined by the medical profession. The decision is not a medical decision."

The petitioners' argument that a physician should not be required to give a patient the choice of a viable mode of treatment which is not "indicated" is contrary to Wisconsin informed consent law. It is axiomatic under that law that a patient has the right to choose among alternate medical modes of treatment that are within the standard of care. There is nothing in the common law or Wis. Stat. § 448.30 that would limit a patient's choice to alternatives that the physician preferred. As Wis. Admin. Code sec. Med 18.03 points out, a physician can "recommend" the treatment that he/she prefers, but cannot dictate it. A standard that would allow for a patient's choice of only the alternatives that the physician felt were "indicated" or preferred would clearly violate § 448.30 and, in fact, would violate the patients right of self determination, the very right claimed by the petitioners here.

When boiled down to its simplest terms, the position of the petitioners simply does not make sense. If a treatment is within the standard of care, it is viable, and the patient must be informed about it. A physician must give a patient the choice of that treatment. If a treatment is outside the standard of care, it need not be disclosed or offered. If among the

treatments that are within the standard of care there is a difference between the patient and the physician as to which treatment is preferred or, in the terms of the petitioners, "indicated," then the patient's wishes prevail. The position of petitioners would radically alter this simple and long-standing rule.

Not only do the petitioners contend that a physician should not be liable under the Wisconsin informed consent doctrine for failing to give a patient the choice of a method of treatment which is viable but not "indicated," but the petitioners are concerned that if a physician provides a treatment which is viable, but not "indicated," the physician may be subject to liability for malpractice. The simple answer to this concern is that if a physician provides the treatment negligently, then he/she should be held subject to liability for malpractice. If the physician provides the treatment with reasonable care, then he/she cannot be subject to liability merely for providing the treatment. By definition, a "viable" mode of treatment is one which is within the standard of care for a physician to provide. Therefore, a physician cannot be held to have violated the standard of care merely for providing the treatment. *See* Wis.J.I. — Civil 1023.

IV.

THE MEDICAL EXAMPLES PROVIDED BY THE PETITIONERS DO NOT PROPERLY REFLECT THE RULING OF THE WISCONSIN COURT.

In erroneously arguing that the Wisconsin court's decision compels a physician to perform whatever procedure is demanded, the petitioners cite two hypothetical fact situations in an attempt to make that point. An examination

of those situations clearly shows that the petitioners have not properly applied the court's decision.

First, the petitioners create a fact situation where a patient with coronary artery blockage is faced with a decision involving three potential treatments: angioplasty, bypass surgery and medication. The petitioners state that all three therapies may be "indicated" for one patient, but that for another patient, the surgery alternative might be the only "indicated" treatment. The petitioners then ask whether this latter patient should have the right to demand the medication alternative. The petitioners further ask whether the physician will be subject to liability if the physician accedes to the patient's request and administers the medication and the patient develops complications which are a known risk of the medication. The answer is simple. If treatment with the medication is a viable mode of treatment, and the physician informs the patient of the risks and benefits of the medication, as required by Wis. Stat. § 448.30, then the physician cannot be held liable under the informed consent doctrine. If the physician acts with reasonable care in administering the medication, the physician cannot be held liable for malpractice. Wis.J.I — Civil 1023. The court's decision in this case does not have any effect on those conclusions.

If treatment with the medication is a viable mode of treatment, then clearly the patient has the right to choose that treatment, whether or not the physician feels that this treatment is preferred or "indicated." That is the essence of the informed consent doctrine. The doctrine has nothing to do with whether the medication is administered by the physician who informs the patient about the medication or by some other physician. The doctrine is concerned with who has the right to make the choice of that treatment. The

supreme court's decision in this case, along with all Wisconsin cases preceding it and Wis. Stat. § 448.30, vest that right with the patient.

A physician has no fear of being sued for malpractice if the patient selects one viable medical mode of treatment, even if the physician recommends a different course of treatment which is also a viable mode of treatment. If the treatment is within the standard of care, then the physician has a clear defense to any claim for malpractice, because a physician cannot be found negligent for administering a recognized alternative method of treatment. Wis.J.I. — Civil 1023. If the treatment is not a viable treatment, the physician should not be offering it. If it is, the patient has the right to choose it, and the physician cannot be liable for providing it.

The second example provided by the petitioners is likewise misguided. It involves a patient who has an abnormal mammogram and then requests a biopsy for "peace of mind." The petitioners argue that a complication from the biopsy could then result in the physician being sued for malpractice for performing a "contraindicated" biopsy. Again, this situation is not difficult to analyze. The physician has no obligation to even offer, much less perform a biopsy, unless it is within the standard of care. If it is, then the patient has the right to select it, even if the physician feels that it is not the preferred or "indicated" method of treatment. If the patient does select the biopsy against the recommendation of the physician, the physician is completely protected from a negligence claim, as long as he performs the procedure with reasonable care.

In this case, there was no dispute that a cesarean section was not only within the standard of care, it was the normal method of delivery for a woman like Janice Schreiber who had had two prior cesarean sections. It was undisputed that because of her two prior cesarean sections, she had to be given the choice of a third cesarean section. It was undisputed that such an option was well within the standard of care, due to the risk of uterine rupture which a VBAC presents. It was undisputed that no one could be critical of Dr. Figge for performing a cesarean section. To argue that Dr. Figge should have the right to deny Mrs. Schreiber the choice of this typically-used alternative merely because he preferred a VBAC is to wholly reject the informed consent doctrine.

V.

THE POSITION ADVOCATED BY THE PETITIONERS WOULD RESULT IN THE VIOLATION OF THE CONSTITUTIONAL RIGHTS OF MEDICAL PATIENTS.

The decision of the Wisconsin court is based directly on the Wisconsin informed consent statute, Wis. Stat. § 448.30. That statute has its roots in both Wisconsin and United States Supreme Court case law which predated the passage of the statute. That case law stands for the proposition that a hallowed right vested in the United States Constitution is the right to control one's own body. The right to control one's own medical treatment, even if some would consider the decision to be unwise, is a constitutionally vested right belonging to any medical patient in this country.

The position advocated by the petitioners would eviscerate that longstanding right by allowing a physician

to continue a treatment that a patient wanted to end. No reasonable construction of the cases supporting the self-determination right of a patient could possibly be read to delegate that cherished right to a physician.

CONCLUSION

For the reasons given above, the Petition should be denied.

Respectfully submitted,

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APPENDIX

APPENDIX — WISCONSIN ADMINISTRATIVE CODE SEC. MED 18.02 & 18.03

Med 18.02 Definitions. (1) "Emergency" means a circumstance in which there is an immediate risk to a patient's life, body part or function which demands prompt action by a physician.

(2) "Experimental treatment" means a mode of treatment which has not been generally adopted by the medical profession.

(3) "Viable" as used in s. 448.30, Stats., to modify the term, "medical modes of treatment" means modes of treatment generally considered by the medical profession to be within the scope of current, acceptable standards of care.

Med. 1803. Communication of alternate modes of treatment. (1) It is the obligation of a physician to communicate alternate viable modes of treatment to a patient. The communication shall include the nature of the recommended treatment, alternate viable treatments, and risks or complications of the proposed treatment, sufficient to allow the patient to make a prudent decision. In the communication with a patient, a physician shall take into consideration:

(a) A patient's ability to understand the information;

(b) The emotional state of a patient; and,

(c) The physical state of a patient,

(2) Nothing in sub. (1) shall be construed as preventing or limiting a physician in recommending a mode of treatment which is in his or her judgment the best treatment for a patient.